

I graduated from nursing school in 1977. In my first year of practice there were two patients who had a great impact on me. The first was John, a man in his mid-twenties with a diagnosis of ‘fever of unknown origin’. Despite antibiotics and consults, John’s fever just got worse and worse. More symptoms appeared. He developed what seemed to be different and unrelated diseases in different organ systems. Finally, after weeks of suffering, John died. It would be another 4 years before the AIDS virus was identified in the United States, and a year after that before scientists gave it that name. But I have no doubt that John was my first AIDS patient.

The other patient I remember well was Mary, who had a more straightforward: stage four ovarian cancer. She had no family in the area and no friends came to visit. She had been admitted to the hospital to die. The standing order for pain medication allowed us to administer something every 4 hours. That was the best we had to offer in the way of palliative care back then. We just kept administering the morphine, knowing that it wasn’t sufficient to alleviate her suffering. It would be another decade before hospice care had a serious impact on end of life pain management.

I have now spent more than three decades in nursing and ministry. I have seen a lot of life, and a lot of death, and a lot of complex decisions made. In trying to discern what is right in these complex situations I ask a series of questions. Does this decision allow for the retention of basic human dignity – which encompasses individual autonomy as well as meaningful relationships? Is it a decision that reflects a commitment to compassionate pain relief? Is there a way to understand the situation as possibly redemptive? Is there a point at which the answer to that question is, simply, “no, not any longer?”

I am convinced that the Compassionate Aid In Dying bill offers an ethical and compassionate option to adults with terminal illness. The legislation would allow a competent adult to request the assistance of a physician to provide them with the means to end their life on their own terms. It is a law that honors personal autonomy and dignifies the end of life with compassionate choice. When a person feels that their suffering is no longer redemptive, that the pain outweighs all other considerations, that person can choose the time of their death.

From my reading, the language of the bill is not coercive; no physician, pharmacist, or health care institution that is uncomfortable with this process need participate. Some opponents may fear that this law could be used to put disabled people to death – the specter of Josef Mengele is always in the background in this debate. But the law as it is written would not allow for that. Only the patient themselves can request, receive, and administer the life-ending medication.

We've come a long way since I sat by John's and Mary's bedside all those years ago offering what felt to me like meager comfort in the face of unrelenting suffering. We have come to terms with the reality that we will live longer and that aging brings with it a whole host of challenges that our forebears could not have imagined. I support this bill because my personal and professional experiences leave me with no doubt that we who opt for a life of intentional choices may also wish to opt for such a death. This bill allows for that choice - safely and compassionately.

Rev. Roberta Finkelstein
Interim Senior Minister
The Unitarian Church in Westport
10 Lyons Plains Road

Westport, CT 06880

uuwestport.org

office: 203-227-7205 ext12

cell: 703-508-1336

roberta@uuwestport.org